

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-014160

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

317 500 1061
FILED APR 11 1963

1. PLACE OF DEATH

2. COUNTY St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN LemayLength of stay in lb
10 Weeks2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before
a. STATE Missouri b. COUNTY St. Louis admission)c. CITY
OR
TOWN St. AnnInside Limits
Yes ☒ No ☐c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION Mt. St. Rose HospitalInside Limits
Yes ☒ No ☐d. STREET ADDRESS (If outside, give location)
3519 St. BlaseReside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)First Middle Last
Donald M. Fleetwood4. DATE OF DEATH Month Day Year
March 25, 1963

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐

8. DATE OF BIRTH

11/25/1925

9. AGE (last birthday)

37

IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Secretary

10b. KIND OF BUSINESS OR INDUSTRY

Secretary

11. BIRTHPLACE (City and state or country)

Gideon Mo.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Fred Fleetwood Sr.

13b. MOTHER'S MAIDEN NAME

Jewell Hogan

14. NAME OF HUSBAND OR WIFE

Norma Ann Fleetwood

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates)

No

No

16. SOCIAL SECURITY NO.

101

17. INFORMANT Address
Norma Ann Fleetwood 3519 St. Blase18. CAUSE OF DEATH (Enter only one cause per time for death, and only one)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pulmonary Artery Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

Immediate

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

Congenital Heart disease

Life

DUE TO (c)

Congestive Heart Failure

Pneumonia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)

Fibrocystic Pulmonary Tuberculosis

PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐20a. ACCIDENT SUICIDE HOMICIDE
☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.
Month, Day, Year20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 1957 to 3/25/63 and last saw him alive on 3/25/63
Death occurred at 5:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

Charles M.D.

22b. ADDRESS

114 E Lockwood, St. Ann, Mo.

22c. DATE SIGNED

3/28/63

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE

3/29/63

23c. NAME OF CEMETERY OR CREMATORY

Mount Lebanon Cemetery

23d. LOCATION (City, town, or county)

St. Ann, Mo.

24. FUNERAL DIRECTOR

ADDRESS

Collier Mortuary, St. Ann, Mo.

25. DATE RECD. BY LOCAL REG.

3-28-63

26. REGISTRAR'S SIGNATURE

John B. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

1 4000

2 40142

3

4 0

5 1

6

7 0

8 1

9 7545A

10

11

12 42-0

13

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address St. Ann Mo.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.
If this body is not embalmed, fact should be so stated above.